NEVADA STATE BOARD OF MEDICAL EXAMINERS
SPECIAL VOLUNTEER MEDICAL LICENSURE

There is no application fee or registration fee required for a Special Volunteer Medical License; there is however, a Criminal Background Investigation fee of $75.00. The Criminal Background Investigation fee is non-refundable.

You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. Any applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten (illegible or incomplete applications will be returned). Applications must be received on single-sided white bond paper, 8 ½" x 11" in size. Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

A SPECIAL VOLUNTEER MEDICAL LICENSE IS GRANTED TO:

A physician who is retired from active practice and who:

- Wishes to donate his or her expertise for the medical care and treatment of persons in this State who are indigent, uninsured or unable to afford healthcare; or
- Wishes to provide services for any disaster relief operations conducted by a governmental entity or nonprofit organization;

The physician will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation for providing medical care under the Special Volunteer Medical License, except payment by a medical facility at which the physician provides volunteer medical services of the expenses of the physician for necessary travel, continuing education, malpractice insurance, or fees of the Nevada State Board of Pharmacy.

During the application process of a Special Volunteer Medical License, the physician must provide proof that he or she has previously been issued an unrestricted license to practice medicine in any state of the United States and that he or she has never been the subject of disciplinary action by a medical board or any other jurisdiction.

The initial Special Volunteer License expires 1 year after the date of issuance. The license may be renewed and any license that is renewed expires 2 years after the date of issuance.

The retired physician must be competent to practice medicine

A physician with a Special Volunteer Medical License must comply with the continuing medical education (CME) requirements for registration renewal which is the following: 40 hours of continuing medical education during the preceding 24 months, 2 hours must be in medical ethics and 20 hours of which must be in the scope of practice or specialty of the holder of the license. The CME must be Category 1 and approved by the AMA.

Per Nevada Revised Statute 630.161, "The Board shall not issue a license to practice medicine to an applicant who has been licensed to practice any type of medicine in another jurisdiction and whose license was revoked for gross medical negligence by that jurisdiction."

The Board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances** warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a 13, 19, 27, 28, 29, 30, 31, 32 and/or 33.

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

In accordance with Nevada Revised Statutes 630.258:

NRS 630.258 Special volunteer medical license.

1. A physician who is retired from active practice and who:

(a) Wishes to donate his or her expertise for the medical care and treatment of persons in this State who are indigent, uninsured or unable to afford health care; or

(b) Wishes to provide services for any disaster relief operations conducted by a governmental entity or nonprofit organization,
➥ may obtain a special volunteer medical license by submitting an application to the Board pursuant to this section.

2. An application for a special volunteer medical license must be on a form provided by the Board and must include:

(a) Documentation of the history of medical practice of the physician;

(b) Proof that the physician previously has been issued an unrestricted license to practice medicine in any state of the United States and that the physician has never been the subject of disciplinary action by a medical board in any jurisdiction;

(c) Proof that the physician satisfies the requirements for licensure set forth in NRS 630.160 or the requirements for licensure by endorsement set forth in NRS 630.1605;

(d) Acknowledgment that the practice of the physician under the special volunteer medical license will be exclusively devoted to providing medical care:

(1) To persons in this State who are indigent, uninsured or unable to afford health care; or

(2) As part of any disaster relief operations conducted by a governmental entity or nonprofit organization; and

(e) Acknowledgment that the physician will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for providing medical care under the special volunteer medical license, except for payment by a medical facility at which the physician provides volunteer medical services of the expenses of the physician for necessary travel, continuing education, malpractice insurance or fees of the State Board of Pharmacy.

3. If the Board finds that the application of a physician satisfies the requirements of subsection 2 and that the retired physician is competent to practice medicine, the Board shall issue a special volunteer medical license to the physician.

4. The initial special volunteer medical license issued pursuant to this section expires 1 year after the date of issuance. The license may be renewed pursuant to this section, and any license that is renewed expires 2 years after the date of issuance.

5. The Board shall not charge a fee for:

(a) The review of an application for a special volunteer medical license; or

(b) The issuance or renewal of a special volunteer medical license pursuant to this section.

6. A physician who is issued a special volunteer medical license pursuant to this section and who accepts the privilege of practicing medicine in this State pursuant to the provisions of the special volunteer medical license is subject to all the provisions governing disciplinary action set forth in this chapter.

7. A physician who is issued a special volunteer medical license pursuant to this section shall comply with the requirements for continuing education adopted by the Board.

(Added to NRS by 2001, 373; A 2003, 1888; 2007, 3044; 2009, 2955)

NRS 630.160 Requirements for license to practice medicine; action by Board if Board receives information concerning applicant that differs from information previously received by Board.

1. Every person desiring to practice medicine must, before beginning to practice, procure from the Board a license authorizing the person to practice.

2. Except as otherwise provided in NRS 630.1605, 630.161 and 630.258 to 630.266, inclusive, a license may be issued to any person who:

(a) Is a citizen of the United States or is lawfully entitled to remain and work in the United States;

(b) Has received the degree of doctor of medicine from a medical school:

(1) Approved by the Liaison Committee on Medical Education of the American Medical Association and Association of American Medical Colleges; or

(2) Which provides a course of professional instruction equivalent to that provided in medical schools in the United States approved by the Liaison Committee on Medical Education;

(c) Is currently certified by a specialty board of the American Board of Medical Specialties and who agrees to maintain the certification for the duration of the licensure, or has passed:

(1) All parts of the examination given by the National Board of Medical Examiners;

(2) All parts of the Federation Licensing Examination;

(3) All parts of the United States Medical Licensing Examination;

(4) All parts of a licensing examination given by any state or territory of the United States, if the applicant is certified by a specialty board of the American Board of Medical Specialties;

(5) All parts of the examination to become a licentiate of the Medical Council of Canada; or

(6) Any combination of the examinations specified in subparagraphs (1), (2) and (3) that the Board determines to be sufficient;

(d) Is currently certified by a specialty board of the American Board of Medical Specialties in the specialty of emergency medicine, preventive medicine or family practice and who agrees to maintain certification in at least one of these specialties for the duration of the licensure, or:

(1) Has completed 36 months of progressive postgraduate:

(I) Education as a resident in the United States or Canada in a program approved by the Board, the Accreditation Council for Graduate Medical Education or the Coordinating Council of Medical Education of the Canadian Medical Association; or

(II) Fellowship training in the United States or Canada approved by the Board or the Accreditation Council for Graduate Medical Education;

(2) Has completed at least 36 months of postgraduate education, not less than 24 months of which must have been completed as a resident after receiving a medical degree from a combined dental and medical degree program approved by the Board; or

(3) Is a resident who is enrolled in a progressive postgraduate training program in the United States or Canada approved by the Board, the Accreditation Council for Graduate Medical Education or the Coordinating Council of Medical Education of the Canadian Medical Association, has completed at least 24 months of the program and has committed, in writing, to the Board that he or she will complete the program; and

(e) Passes a written or oral examination, or both, as to his or her qualifications to practice medicine and provides the Board with a description of the clinical program completed demonstrating that the applicant's clinical training met the requirements of paragraph (b).

3. The Board may issue a license to practice medicine after the Board verifies, through any readily available source, that the applicant has complied with the provisions of subsection 2. The verification may include, but is not limited to, using the Federation Credentials Verification Service. If any information is verified by a source other than the primary source of the information, the Board may require subsequent verification of the information by the primary source of the information.

4. Notwithstanding any provision of this chapter to the contrary, if, after issuing a license to practice medicine, the Board obtains information from a primary or other source of information and that information differs from the information provided by the applicant or otherwise received by the Board, the Board may:

(a) Temporarily suspend the license;

(b) Promptly review the differing information with the Board as a whole or in a committee appointed by the Board;

(c) Declare the license void if the Board or a committee appointed by the Board determines that the information submitted by the applicant was false, fraudulent or intended to deceive the Board;

(d) Refer the applicant to the Attorney General for possible criminal prosecution pursuant to NRS 630.400; or

(e) If the Board temporarily suspends the license, allow the license to return to active status subject to any terms and conditions specified by the Board, including:

(1) Placing the licensee on probation for a specified period with specified conditions;

(2) Administering a public reprimand;

(3) Limiting the practice of the licensee;

(4) Suspending the license for a specified period or until further order of the Board;

(5) Requiring the licensee to participate in a program to correct alcohol or drug dependence or any other impairment;

(6) Requiring supervision of the practice of the licensee;

(7) Imposing an administrative fine not to exceed $5,000;

(8) Requiring the licensee to perform community service without compensation;

(9) Requiring the licensee to take a physical or mental examination or an examination testing his or her competence to practice medicine;

(10) Requiring the licensee to complete any training or educational requirements specified by the Board; and

(11) Requiring the licensee to submit a corrected application, including the payment of all appropriate fees and costs incident to submitting an application.

5. If the Board determines after reviewing the differing information to allow the license to remain in active status, the action of the Board is not a disciplinary action and must not be reported to any national database. If the Board determines after reviewing the differing information to declare the license void, its action shall be deemed a disciplinary action and shall be reportable to national databases.

[Part 8:169:1949; A 1953, 662; 1955, 103]—(NRS A 1969, 211; 1971, 220; 1973, 508; 1977, 1564; 1985, 2229; 1987, 193, 1673; 1989, 416; 1991, 1068, 1884, 1887; 1993, 2298; 1997, 680; 2001, 761; 2003, 437, 1886; 2007, 1824, 3042; 2009, 1105, 2950; 2011, 887)

NRS 630.1605 Requirements for license by endorsement to practice medicine.

1. Except as otherwise provided in NRS 630.161, the Board may issue a license by endorsement to practice medicine to an applicant who has been issued a license to practice medicine by the District of Columbia or any state or territory of the United States if:

(a) At the time the applicant files an application with the Board, the license is in effect;

(b) The applicant:

(1) Submits to the Board proof of passage of an examination approved by the Board;

(2) Submits to the Board any documentation and other proof of qualifications required by the Board;

(3) Meets all of the statutory requirements for licensure to practice medicine in effect at the time of application except for the requirements set forth in NRS 630.160; and

(4) Completes any additional requirements relating to the fitness of the applicant to practice required by the Board; and

(c) Any documentation and other proof of qualifications required by the Board is authenticated in a manner approved by the Board.

2. A license by endorsement to practice medicine may be issued at a meeting of the Board or between its meetings by the President and Executive Director of the Board. Such an action shall be deemed to be an action of the Board.

(Added to NRS by 2003, 1886; A 2007, 1825; 2009, 2952, 2999)

SPECIAL VOLUNTEER PHYSICIAN
APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT

_____	a.	APPLICATION: ☐ Properly completed, signed and notarized application, including pages 1 – 7, Applicant Responsibility statement, and Criminal Background Investigation report authorization form; ☐ Recent passport quality photograph (at least 2"x 2") attached to application, signed in ink on lower front edge; ☐ Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 14, 19, 27, 28, 29, 30, 31, 32, and 33; ☐ Release form, signed and notarized (Form A);
_____	b.	FEES: • Criminal background investigation fee – cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. Note: Criminal background investigation fees are non-refundable;
_____	c.	IDENTITY (Important identity documents will be returned to you via secured mail): U.S. born citizens – Original or Certified Birth Certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable); • Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport; • Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa;
_____	d.	SELF-QUERY VERIFICATION: • Self-query response from the National Practitioner Data Bank (NPDB); see enclosed instruction sheet. The NPDB will send the report directly to you and you will forward the final report to the Board office;
_____	e.	SUPPLEMENTARY FORM: • FORM B: ONLY if you have answered affirmatively to either of the two malpractice questions on the application;
_____	f.	BOARD CERTIFICATION: • Copy of American Board of Medical Specialties (ABMS) Board certification certificate(s), copy of ABMS Board re-certification certificate(s); • If you hold "lifetime or historical" ABMS Board certification, a notarized statement agreeing to maintain Board certification (include name of the Board) for the duration of your licensure in the state of Nevada;
_____	g.	CONTINUING EDUCATION: • Proof of 4 hours bioterrorism AMA Category 1 continuing medical education (CME) relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. Search for an online course by entering "AMA Category 1 bioterrorism continuing medical education" or take a classroom course;
_____	h.	VOLUNTEER APPLICANT LETTER TO THE BOARD: • A letter indicating that the physician is applying for a Special Volunteer Medical License and the physician will exclusively devote medical care to the indigent persons or to provide services for any disaster relief operations conducted by a governmental entity or nonprofit organization. The letter must indicate name and address of the organization in which he will be volunteering and that he will not receive *any* payment or compensation, either direct or indirect, or have expectation of any payment or compensation for providing medical care under the Special Volunteer Medical License, except payment by a medical facility at which the physician provides volunteer medical services at the expense of the physician for necessary travel, continuing education, malpractice insurance, or the fees of the Nevada State Board of Pharmacy.

SPECIAL VOLUNTEER PHYSICIAN
APPLICATION CHECKLIST

DIRECT SOURCE VERIFICATIONS TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN BY THE VERIFYING INSTITUTION TO BOARD OFFICE

Verifying agencies may charge a fee. ***Do not provide pre-stamped or pre-addressed envelopes for direct source verifications.***

_____	*	a.	MEDICAL SCHOOL: ☐ Verification of Medical Education (Form 1) to be completed by medical school(s); ☐ Official transcripts from all schools where professional medical instruction was received (if transcripts are not in English, a certified original and official English translation is required);
_____	*	b.	POSTGRADUATE TRAINING PROGRAM: • Certificate of Completion of Progressive Postgraduate Training (Form 2) to be completed by all institutions where any training occurred (internship, residency, fellowship and research fellowship);
_____	*	c.	EXAMINATION: ☐ Certification of National Board, FLEX, USMLE, LMCC or SPEX scores - see instruction page. For State written examination certification – use Form 4; **Note: In the state of Nevada, for United States Medical Licensing Examination (USMLE) a person must pass Steps I, II and III of the USMLE within 7 years after the date on which the person first passes any step of the USMLE and a person is limited to a combined maximum of 9 attempts to pass steps I, II, and III and no more than 3 attempts at step III of the USMLE.** ☐ Certification status report from the Educational Commission for Foreign Medical Graduates (ECFMG) – see instruction page;
_____		d.	BOARD CERTIFICATION: ☐ Verification of ABMS Board certification, if applying via state written exam/board certification; ☐ Verification of ABMS Board certification (direct source) if lifetime / historically board certified;
_____		e.	LICENSE VERIFICATIONS: • License verification (Form 3) from all states where applicant is currently licensed or has ever been licensed (this does not include training licenses or temporary permits);
_____		f.	HOSPITAL VERIFICATIONS: • Verification of hospital privileges Form 5 to be completed by appropriate entity and returned directly by the verifying institution to the Board office if you answered affirmatively to having had any disciplinary issues regarding your hospital privileges within the past 10 years (see Disclaimer below);
_____		g.	MALPRACTICE INSURANCE CARRIER VERIFICATIONS: • Malpractice insurance carrier verification (Form 6) to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report for any and all malpractice cases that occurred within the past 10 years (see Disclaimer below);
_____		h.	LETTER FROM ORGANIZATION WHERE APPLICANT WILL BE VOLUNTEERING: Letter from the organization which the physician will volunteer indicating that the physician will exclusively provide medical care to indigent persons in the state of Nevada and the location of the organization. The organization must indicate that the physician will not receive any payment or compensation for providing medical care under the Special Volunteer Medical License, except for payment by a medical facility at which the physician provides volunteer medical services at the expenses of the physician for necessary travel, continuing medical education, malpractice insurance, or fees of the Nevada State Board of Pharmacy;
_____		i.	FINGERPRINT RESULTS: • FBI Criminal history background report – returned directly by the verifying institution to the Board office. **(Once application fees have been received, a fingerprint card and instructions will be mailed to the applicant. Note: The Board fingerprint card contains the necessary Board account numbers required for processing.)**

***** Federation Credentials Verification Service (FCVS) packet may verify these documents.

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

APPLICATION GUIDE

Identity - Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name (i.e., U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or other legal documentation reflecting name change).

Postgraduate Training - If you have ever had any actions, forms of remediation, restrictions or limitations imposed on you, or have been placed on probation while participating in any type of training program, you should answer affirmatively to question #19. Submit a signed and dated explanation addressed to the Board and copies of documentation you received from your program.
[i.e., explanation addressed to the Board for any postgraduate training issues.]

Malpractice - Provide signed and dated explanations for all malpractice cases throughout your career. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed which includes copies of Complaints, Settlements and/or Dismissals. If you have a pending case or cases, request a letter from your attorney to be sent directly to the Board describing the current status of the case(s).
[i.e., explanations for all cases addressed to the Board during your medical career answering who, what, where, when and why; copies of legal documents for the past 10 years.]

Investigation - If you have ever been notified that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violations of a statute, rule or regulation governing your practice as a physician, you should answer affirmatively to question #31 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation unless otherwise instructed.

VERIFICATIONS THAT MAY BE EXPECTED FROM A DIRECT SOURCE OTHER THAN WHAT IS OUTLINED ON THE CHECKLIST

- Observerships, Externships, Research positions or Research Fellowships prior to completion of your postgraduate training in the United States or Canada.
- Employment in a medical setting between medical school and postgraduate training or in between postgraduate training years and prior to completion of your postgraduate training in the United States or Canada.

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information that is more than 10 years old regarding malpractice, investigations by another licensing board, complaints or disciplinary actions from a hospital, clinic or medical facility if the Board receives the information from the applicant or any other source from which the Board is verifying the information provided by the applicant.

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

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I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name _____

Sign your name _____

Date _____

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

INSTRUCTIONS FOR REQUESTING EXAMINATION SCORES, "BOARD ACTION HISTORY REPORT" AND NATIONAL PRACTITIONER DATA BANK "SELF QUERY"

NATIONAL PRACTITIONER DATA BANK'S "PRACTITIONER REQUEST" FOR INFORMATION DISCLOSURE (SELF-QUERY):

The request form for the National Practitioner Data Bank (NPDB) is available at http://www.npdb.hrsa.gov. Click on "How to Get Started" under the Practitioners column on the left side of the page and follow the instructions provided. If you require additional information, please call the NPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB, forward a copy of this report to the Board office.

FLEX, SPEX and USMLE AND BOARD ACTION HISTORY REPORT (EBAHR) FROM THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES

The Federation of State Medical Boards of the United States, Inc.'s EBAHR will certify a complete history of your scores for a designated examination(s). The Federation maintains scores for FLEX, SPEX, and the USMLE Steps 1, 2, and 3.
Request transcripts online at www.fsmb.org/transcripts.html. For questions or assistance, please call (817) 868-4041 or email usmle@fsmb.org.

NATIONAL BOARD SCORES:

NBME scores must be received directly from the National Board of Medical Examiners. The request form for the National Board of Medical Examiners is available on the NBME web site: https://apps.nbme.org/ciw2/prod/jsp/login.jsp. If you have difficulty accessing the form, please call the NBME at (215) 590-9592.

LMCC EXAMINATION TRANSCRIPT OF SCORES

Navigate to this website: www.mcc.ca. Click on **English; go** to **MCC documents** on the menu line; then go to **Certified Transcript of Examinations**. Click on **Service Request Form**. Print the Service Request Form and complete it. Mail it along with your check to the address on the top of the form. Or, if you are paying by credit card, you can fax the form to the fax number located on the form itself and also on the instruction page. For questions or assistance, please call (613) 521-6012.

ECFMG VERIFICATIONS

International medical graduates must contact the ECFMG for certification status to be sent to the Nevada State Board of Medical Examiners. You can contact ECFMG's Applicant Information Services at (215) 386-5900. The request form can be found on ECFMG's website at www.ecfmg.org. If you are using FCVS, you do not need to contact the ECFMG; FCVS will coordinate with the ECFMG to obtain your certification.

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:

NRS 630.301 Criminal offenses; disciplinary action taken by other jurisdiction; surrender of previous license while under investigation; malpractice; engaging in sexual activity with patient; disruptive behavior; violating or exploiting trust of patient for financial or personal gain; failure to offer appropriate care with intent to positively influence financial well-being; engaging in disreputable conduct; engaging in sexual contact with surrogate of patient or relatives of patient. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.
2. Conviction of violating any of the provisions of NRS 616D.200, 616D.220, 616D.240, 616D.300, 616D.310, or 616D.350 to 616D.440, inclusive.
3. Any disciplinary action, including, without limitation, the revocation, suspension, modification or limitation of a license to practice any type of medicine, taken by another state, the Federal Government, a foreign country or any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the Armed Services of the United States, an insurance company, an agency of the Federal Government or an employer.
4. Malpractice, which may be evidenced by claims settled against a practitioner, but only if the malpractice is established by a preponderance of the evidence.
5. The engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner.
6. Disruptive behavior with physicians, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.
7. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain.
8. The failure to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an appropriate provider, when the failure occurs with the intent of positively influencing the financial well-being of the practitioner or an insurer.
9. The engaging in conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics.
10. The engaging in sexual contact with the surrogate of a patient or other key persons related to a patient, including, without limitation, a spouse, parent or legal guardian, which exploits the relationship between the physician and the patient in a sexual manner.
11. Conviction of:

(a) Murder, voluntary manslaughter or mayhem;
(b) Any felony involving the use of a firearm or other deadly weapon;
(c) Assault with intent to kill or to commit sexual assault or mayhem;
(d) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
(e) Abuse or neglect of a child or contributory delinquency;
(f) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or
(g) Any offense involving moral turpitude.

(Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236; 1987, 197; 1991, 1070; 1993, 782; 1997, 684; 2001, 766; 2003, 2707, 3433; 2003, 20th Special Session, 264, 265; 2005, 2522; 2007, 3045; 2011, 847)

NRS 630.304 Misrepresentation in obtaining or renewing license; false advertising; practicing under another name; signing blank prescription forms; influencing patient to engage in sexual activity; discouraging second opinion; terminating care without adequate notice. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.
2. Advertising the practice of medicine in a false, deceptive or misleading manner.
3. Practicing or attempting to practice medicine under another name.
4. Signing a blank prescription form.
5. Influencing a patient in order to engage in sexual activity with the patient or with others.
6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.
7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.

(Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception.

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

(a) Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.
(b) Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.
(c) Referring, in violation of NRS 439B.425, a patient to a health facility, medical laboratory or commercial establishment in which the licensee has a financial interest.
(d) Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.
(e) Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the Board.
(f) Delegating responsibility for the care of a patient to a person if the licensee knows, or has reason to know, that the person is not qualified to undertake that responsibility.
(g) Failing to disclose to a patient any financial or other conflict of interest.
(h) Failing to initiate the performance of community service within 1 year after the date the community service is required to begin, if the community service was imposed as a requirement of the licensee's receiving loans or scholarships from the Federal Government or a state or local government for the licensee's medical education.

2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of NRS 636.373.

(Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065 (cont.):

NRS 630.306 Inability to practice medicine; deceptive conduct; violation of regulation governing practice of medicine or adopted by State Board of Pharmacy; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient or patient's family; lack of skill or diligence; habitual intoxication or dependency on controlled substances; filing of false report; failure to report certain changes of information or disciplinary or criminal action in another jurisdiction; failure to be found competent after examination; certain operation of a medical facility; prohibited administration of anesthesia or sedation; engaging in unsafe or unprofessional conduct; knowingly procuring or administering certain controlled substances or dangerous drugs; failure to supervise medical assistant adequately. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance.
2. Engaging in any conduct:
(a) Which is intended to deceive;
(b) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or
(c) Which is in violation of a regulation adopted by the State Board of Pharmacy.
3. Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law.
4. Performing, assisting or advising the injection of any substance containing liquid silicone into the human body, except for the use of silicone oil to repair a retinal detachment.
5. Practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training.
6. Performing, without first obtaining the informed consent of the patient or the patient's family, any procedure or prescribing any therapy which by the current standards of the practice of medicine is experimental.
7. Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.
8. Habitual intoxication from alcohol or dependency on controlled substances.
9. Making or filing a report which the licensee or applicant knows to be false or failing to file a record or report as required by law or regulation.
10. Failing to comply with the requirements of NRS 630.254.
11. Failure by a licensee or applicant to report in writing, within 30 days, any disciplinary action taken against the licensee or applicant by another state, the Federal Government or a foreign country, including, without limitation, the revocation, suspension or surrender of a license to practice medicine in another jurisdiction.
12. Failure by a licensee or applicant to report in writing, within 30 days, any criminal action taken or conviction obtained against the licensee or applicant, other than a minor traffic violation, in this State or any other state or by the Federal Government, a branch of the Armed Forces of the United States or any local or federal jurisdiction of a foreign country.
13. Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318.
14. Operation of a medical facility at any time during which:
(a) The license of the facility is suspended or revoked; or
(b) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.

➥ This subsection applies to an owner or other principal responsible for the operation of the facility.

15. Failure to comply with the requirements of NRS 630.373.
16. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board.
17. Knowingly procuring or administering a controlled substance or a dangerous drug as defined in chapter 454 of NRS that is not approved by the United States Food and Drug Administration, unless the unapproved controlled substance or dangerous drug:
(a) Was procured through a retail pharmacy licensed pursuant to chapter 639 of NRS;
(b) Was procured through a Canadian pharmacy which is licensed pursuant to chapter 639 of NRS and which has been recommended by the State Board of Pharmacy pursuant to subsection 4 of NRS 639.2328; or
(c) Is marijuana being used for medical purposes in accordance with chapter 453A of NRS.
18. Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.

(Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575; 2007, 3046; 2009, 533, 879, 2961, 2962; 2011, 257, 2612)

NRS 630.3062 Failure to maintain proper medical records; altering medical records; making false report; failure to file or obstructing required report; failure to allow inspection and copying of medical records; failure to report other person in violation of chapter or regulations. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.
2. Altering medical records of a patient.
3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.
4. Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061.
5. Failure to comply with the requirements of NRS 630.3068.
6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.

(Added to NRS by 1985, 2223; A 1987, 199; 2001, 767; 2002 Special Session, 19; 2003, 3433; 2009, 2963)

NRS 630.3065 Willful disclosure of privileged communication; willful failure to comply with statute or regulation governing practice of medicine. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Willful disclosure of a communication privileged pursuant to a statute or court order.
2. Willful failure to comply with:
(a) A regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician;
(b) A court order relating to this chapter; or
(c) A provision of this chapter.
3. Willful failure to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of NRS 439B.410.

(Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302)

SPECIAL VOLUNTEER
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Date Received by Board

License No._____
File No. _____

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 (For Board Use Only)

1. Present Legal Name _____
Last First Middle Maiden

List any other name(s) ever used _____

2. Mailing Address _____
Street City County State Zip

3. Home Address _____
Street City County State Zip

4. Telephone Numbers (____)_____ (____)_____ (____)_____ (____)_____
Office Fax Home Cellular (Optional)

Email address _____

5. Date of Birth _____ Place of Birth _____Gender____F____M
(Month / Day / Year) (City, State, Country)

6. Citizenship: U.S. Citizen _____ Alien Registration # _____Employment Authorization # _____ Applying for Visa _____
Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration Card, Employment Authorization card or Visa. Please note: Copy of document authorizing a name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____

NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board.
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.
NRS 630.173(2) The Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE ATTACHED SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No _____N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No _____N/A

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissed, or expungement. _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

14. Have you previously applied for medical licensure in Nevada (including in a Residency program)? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.**

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance (Month/Day/Year)

17. List all ACGME* approved postgraduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

18. List non-ACGME Fellowship training or non-ACGME combined postgraduate medical education attended in the United States or Canada.

If combined program list Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

19. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, form of remediation(s), restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#:_____

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained. (Also include failed examinations.) FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.

21a. State Written Examination:

Location	Date (Mo./Yr.)	Results (Scores)

21b. NATIONAL BOARD (not ABMS Board certification): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Part Taken	Date (Mo./Yr.)	Results (Two Digit Scores)

(If more space is needed, please attach a separate sheet of paper.)

21c. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Date (Mo./Yr.)	Results (FLEX weighted average)

(If more space is needed, please attach a separate sheet of paper.)

21d. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Step Taken	Date (Mo./Yr.)	Results (Three Digit Scores)	Number of Attempts

(If more space is needed, please attach a separate sheet of paper.)

21e. LMCC (Licentiate of the Medical Counsel of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Part Taken	Date (Mo./Yr.)	Results (Scores)

21f. SPEX (Special Purpose Examination):

Location	Date (Mo./Yr.)	Results (Scores)

22. State your scope of practice/specialty (ies): _____

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES** (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS)**.**

Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification and/or Recertification (Mo./Yr.)

24. Account for, **in chronological order**, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. (Curriculum Vitae cannot be submitted in lieu of your answer to this question.)**

Activities	Location (City/State/Country)	From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

25. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

26. List any and all licenses (including training licenses and permits) **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country.

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status

(All information must begin on the application, if more space is needed, please attach separate sheet.)

27. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

28. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

29. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

30. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

31. Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

32. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

33. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all) resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. _____Yes _____No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

Applicant: _____ Date: _____

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada via telemedicine and whose physical presence exists outside the state of Nevada or the United States

I hereby agree that as a condition of obtaining or maintaining licensure with the Board, I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change, and that the failure to do so may subject me to a fine or disciplinary action as allowed in NRS 630.244.

Printed Name of Applicant/Licensee: _____

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

Date: _____

APPLICANT PHOTOGRAPH:

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

_____ _____

Signature of applicant **Date**

APPLICATION AFFIRMATION

I, _____,
(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

_____ _____
Signature of applicant **Date**

(NOTARY SEAL)

State of _____ County of _____
Subscribed and sworn to before me this _____ day of
_____, 2_____.
Notary Public for the State of _____
My Commission Expires: _____
Residing at: _____
City State

_____
Signature of Notary

FORM A

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the state of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

A photocopy of this form will serve as an original.

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
or
1105 Terminal Way #301
Reno, NV 89502

FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers.

Name of Insured: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

(If more space is needed, please copy this page or attach a separate sheet.)

Applicant: Each medical school where instruction was received must complete this form. If more than one medical school was attended, photocopies of this blank form may be made and used.

FORM 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF MEDICAL EDUCATION

This certifies that _____
(name of applicant)

was enrolled in _____
(name of Medical School) (Location – City / State / Country)

The following information to be completed by program only.

The undersigned further certifies that the records of this institution show that the applicant attended this institution

from _____ to _____
(month / year) (month / year)

Please check one:

☐ The applicant was granted a medical degree by

☐ The applicant withdrew from

the above named Medical School on _____
(month / day / year)

ADVANCED (TRANSFER) CREDITS – Credits Granted Upon Admission from another Medical Institution

_____ _____ _____
(name of Medical or Professional School) (total credits) (dates attended - month/ year to month/ year)

Signed and the institutional seal affixed this

_____ day of _____ , 2 _____

By: _____
(typed name and title of President, Registrar or Dean)

Title: _____

Affix Seal Here

Signature: _____
(signature of President, Registrar or Dean) **

Telephone: _____
Fax: _____
Email: _____

** Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners

PO Box 7238
Reno, NV 89510

OR

1105 Terminal Way, Ste 301
Reno, NV 89502

Applicant: Each institution where Internship, Residency and/or Fellowship training was received must complete this form.
If more than one institution was attended, photocopies of this blank form may be made and used.

FORM 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF POSTGRADUATE TRAINING

Institution: ______________________ Affiliated University: ______________________

Address: ______________________

Name of Physician: ______________________

DOB: __________ SS#: __________ Medical School: ______________________

The following information is to be completed by program only.

IMPORTANT – Program Participation:

- Report incomplete postgraduate years (PGY) separately from those that were successfully completed.
- If the postgraduate year is currently "In Progress", report the expected completion in the "To" field.
- Report Internships, Residencies and Fellowships separately.

PG/Year: __________ **DEPARTMENT / SPECIALTY:** ______________________
(e.g., 1, 2, 3, etc.)

- ☐ **Internship**
- ☐ **Residency**
- ☐ **Fellowship**
- ☐ **Research**

From: ____/____/____ **To:** ____/____/____

Successfully Completed? ☐ **Yes** ☐ **No** ☐ **In Progress**

PG/Year: __________ **DEPARTMENT / SPECIALTY:** ______________________
(e.g., 1, 2, 3, etc.)

- ☐ **Internship**
- ☐ **Residency**
- ☐ **Fellowship**
- ☐ **Research**

From: ____/____/____ **To:** ____/____/____

Successfully Completed? ☐ **Yes** ☐ **No** ☐ **In Progress**

PG/Year: __________ **DEPARTMENT / SPECIALTY:** ______________________
(e.g., 1, 2, 3, etc.)

- ☐ **Internship**
- ☐ **Residency**
- ☐ **Fellowship**
- ☐ **Research**

From: ____/____/____ **To:** ____/____/____

Successfully Completed? ☐ **Yes** ☐ **No** ☐ **In Progress**

Indicate the correct response to the following three questions:

Accreditation:

1. Is this training approved by the Accreditation Council for Graduate Medical Education (ACGME) or Coordinating Council of Medical Education (CCME) of the Canadian Medical Association? ☐ **Yes** ☐ **No**

Unusual Circumstances:

2. Did this individual ever take a leave of absence or break from their training? If yes, please explain. ☐ **Yes** ☐ **No**
3. Was this individual disciplined and/or placed under investigation or on probation? ☐ **Yes** ☐ **No**

Please explain "Yes" response(s) to questions #2 and/or #3. If necessary, you may continue your explanation on a separate sheet of paper.

____

____

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

This section MUST be signed by the Program Director (M.D. or D.O. only)**
**Signature by personnel other than an M.D. or D.O. must attach an authorization letter.

Name: ______________________ ☐ **M.D.** ☐ **D.O.** Title: ______________________

Signature: ______________________ Date of Signature: ______________________

Telephone: ______________ Fax: ______________ E-mail: ______________

Completed form is to be returned by the verifying institution directly to:
Nevada State Board of Medical Examiners

PO Box 7238
Reno, NV 89510

OR

1105 Terminal Way, Ste 301
Reno, NV 89502

Applicant: ***Each state where licensure is or was held excluding training licenses and permits must be verified. If licensed in more than one state, photocopies of this blank form may be made and used. You may want to contact the state(s) where you were licensed since some states charge a fee for license verifications and some do not. The direct-source verification of your license does not have to be completed on this form. It is a courtesy form which provides the Board's address.***

FORM 3

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF STATE LICENSURE

PART 1 – TO BE COMPLETED BY APPLICANT

Printed Name of Applicant: ____

Address: ____
(street) (apt. or suite #) (city) (state) (zip)

Date of Birth: ______________________
(month) (day) (year)

I am in the process of applying for medical licensure in the state of Nevada. I hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners at the address below.

____
(signature of applicant)

- -

PART 2 – TO BE COMPLETED BY LICENSING AGENCY

I certify that ____ who
(name of applicant)

graduated from ____
(name and location of Medical School)

on ________________ was granted license number ________________ by the state of ____________
(date of graduation)

on ________________ on the basis of ____.
(date of issuance) (examination: NB / FLEX / USMLE / LMCC / State Licensing examination)

I certify that the above license is: _______ current, in good standing
_______ not current, due to non-payment of fees
_______ subject to pending disciplinary charges
_______ subject to restriction of licensure or practice
_______ other (please attach explanation)

I certify that the records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license.

NOTE: If any portion of this form is deleted or modified, please attach an explanation.

____
(signature of certifying individual)

____
(title of certifying individual)

____
(licensing agency name)

____
(date of signature)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
PO Box 7238 **OR** **1105 Terminal Way, Ste 301**
Reno, NV 89510 **Reno, NV 89502**
(775) 688-2559

Applicant: ***This form to be completed ONLY if applying via state written examination with current ABMS certification.***
This form is to be completed by the state-licensing agency where examination was taken.

FORM 4

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF STATE LICENSING EXAMINATION

I certify that _____, who
(name of applicant)

graduated from _____
(name and location of Medical School)

on _____, was granted license number _____ on _____
(date of graduation) (date of issuance)

on the basis of the licensing agency regular written examination of the state of _____.

I further certify that this physician passed the regular written examination given by this licensing agency on _____
(date)

and obtained a general average of _____ percent in the following subjects. A score of _____ is

considered a passing score.

Subjects of Examination	Percent	Subjects of Examination	Percent

I certify that this license is valid, current, has never been suspended or revoked, and will expire on _____;
(date)

OR this license was valid, was never suspended or revoked, and expired on _____.
(date)

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

_____ _____
(type or print name and title of agency official) (name of state licensing agency)

_____ _____
(signature of agency official) (address)

_____ _____
(date) (phone number)

(affix licensing agency seal)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
(775) 688–2559

If you answered affirmatively to questions #31 and/or #33 on the Application for Licensure, submit this form to all hospitals where you have had privileges within the past 10 years. If more than one hospital or surgery center, photocopies of the blank form may be made and used.

FORM 5

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF HOSPITAL OR SURGERY CENTER PRIVILEGES

Hospital: _____
Attn: Medical Staff Office
Address: _____
_____

Name: _____
DOB: _____
Specialty: _____
Affiliation dates:_____

The above named physician submitted an application to obtain a medical license in Nevada. The applicant has indicated that he/she holds or has held staff privileges at your hospital. In order that the processing of the application may be completed, we ask that you provide us with the information requested below.

1. What privileges are/were extended to the applicant? _____
_____

2. Dates of hospital privileges: From_____ To_____
month / year month / year

3. Have staff privileges ever been limited, restricted, suspended or revoked? No_____ Yes__
If Yes, please explain: _____
_____

4. Is there any derogatory information on file? No _____ Yes_____ If Yes, please explain:
_____
_____

5. Do your records indicate applicant having privileges at any other hospitals in your area?
No_____ Yes_____ If Yes, please attach list.

_____
Signature:
Hospital Chief-of-Staff or Administrator

_____
Typed Name, Title and Date

Phone #_____
Fax #_____
Email_____

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510 (Mailing Address)
1105 Terminal Way, Suite 301
Reno, NV 89502 (Physical Address)
Phone: (775) 688-2559

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.

_____
Medical Doctor (applicant) signature and date

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, submit this form to all malpractice carriers verifying all coverage within the past 10 years. If more than one malpractice carrier, photocopies of the blank form may be made and used.

FORM 6

MALPRACTICE INSURANCE CARRIER VERIFICATION

Insurance Carrier Information:

Name of Insured Physician**:** _____
Name of Insurance Company: _____
Address: _____
_____
_____
Phone: _____ Fax: _____

(To be completed by verifying agency only)

Policy Number: _____
Policy Period From: _____ To: _____

******Please provide a loss history report with this verification.**

Claims Experience:

Has this Physician had a settlement paid on his/her behalf? _____No _____Yes

If "yes", please provide the following information:

Occurrence Date	*Status*	*Date Closed*	*Indemnity Amount*

Description of Claim: _____
_____

Occurrence Date	*Status*	*Date Closed*	*Indemnity Amount*

Description of Claim: _____
_____

Insurance Carrier Agent:

_____
Print Name and Title

_____
Telephone

_____
Signature of Agent

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510 (Mailing Address)
1105 Terminal Way #301
Reno, NV 89502 (Physical Address)
Phone: (775) 688-2559

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.

_____
Medical Doctor (applicant) signature and date

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

PERMISSION TO SEEK CRIMINAL BACKGROUND INVESTIGATION REPORT AND TO OBTAIN AND USE A SET OF MY FINGERPRINTS IN THIS REGARD

I understand that all applicants applying for licensure with the Nevada State Board of Medical Examiners, pursuant to Nevada Revised Statutes Chapter 630, must submit a full set of his/her fingerprints, along with an authorization for the Nevada State Board of Medical Examiners to forward his/her fingerprints to the Department of Public Safety Records and Technology Division and to the Federal Bureau of Investigation for a state and federal criminal background investigation and report.

I herewith and hereby grant permission and fully authorize the Nevada State Board of Medical Examiners to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports.

I UNDERSTAND THAT THE COSTS OF FINGERPRINTING, THE BACKGROUND CHECK AND THE REPORT SHALL BE AT MY OWN EXPENSE.

Dated this _____ day of _____, 2_____.

_____

Signature of Applicant

_____

Print Name

By signing my signature on the line below, I do hereby understand that I must timely submit my fingerprints to the Nevada State Board of Medical Examiners in order for the Board to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports. Failure to do so could result in disciplinary action, up to and including immediate summary suspension of my license. NRS 630.167.

_____

Signature of Applicant **Date**

Return this form to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301, Reno, NV 89502
or
P.O. Box 7238
Reno, NV 89510

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510-7238
or fax to:
775-688-2321

***Please type or print legibly*.**

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Credit Card Number: _____

Expiration Date: _____ / _____
(MM) (YYYY)

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____